HBD-12

Introduction	Members with active employment status must complete and submit an HBD-12 form to their employer before enrolling for health benefits. Employers keep the completed HBD-12 in a file and should give the member a copy.

HBD-12 Instructions

Members and Employers

The table below <u>details the steps</u> you must take to complete an HBD-12 form.

Active Members	Employers
Please complete the following boxes 1, 2, 3, 4A, 4B, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 19, 20 and 21.	Please complete the following boxes 14, 15, 16, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35.
Contact your employer's Health Benefits Officer (HBO) or Personnel Office if you require further assistance.	If an employee requires assistance completing this form, please provide support where possible.
MEMBER'S BOXES are **white**.	*EMPLOYER'S BOXES* are **shaded gray**.

Retired Members	To make an Open Enrollment change, complete the request form **HBD-30**, and mail it to CalPERS. If you prefer, you may call CalPERS to make changes over the phone. All changes are subject to verification of eligibility.

Mail HBD-30 requests to:	**Or contact:**
Office of Employer & Member Health Services P.O. Box 942714 Sacramento, CA 94229-2714	**CalPERS** (with questions on the HBD-12…if applicable) Toll Free: **888 CalPERS** (or **888**-225-7377) **TTY**: 800-735-2929 **FAX**: 916-795-1277

Box	Process
1 *Type of Action* (required)	**Check one:** | **New**	Not enrolled
Change	Is enrolled and either: • Changing health plans (when authorized) • Adding family members • Deleting family members • Changing to a Medicare Coordinated plan (at retirement)
Cancel	Canceling all coverage	
2 and **3** *Social Security Number* (required)	Enter your Social Security Number (SSN) and spouse or domestic partner's SSN. You may process this form without a SSN; however, *you must provide each one* as soon as possible.
4A *Name* and *Mailing Address*	Enter your name as shown on the appointment document. *Do not use nicknames.* Enter your RESIDENCE or mailing address.
4B *Residence ZIP Code*	Enter a ZIP Code to find an eligibility ZIP Code. If a mailing address is different from the residential address, include the Residence ZIP Code in Box 4B. If you decide to use a work ZIP Code, include that ZIP Code in Box 4A.
5 *Permanent Intermittent* (State/CSU Only)	Check this box if you are a Permanent Intermittent (PI) employee.
6 and **7** *Sex* and *Marital Status*	Check the appropriate box: **Yes**- if married, separated **No**- if unmarried or received a final divorce decree
8 and **9** *Plan Code* and *Health Plan*	Refer to the "*Health Program Guide*" or CalPERS On-Line at **www.calpers.ca.gov,** by searching in the *Health Program Publications* section. Enter the correct plan code and the name of the health plan.

HBD-12 Instructions (continued)

Box	Process
10 **_Gross Premium_**	Using the applicable rate sheet, enter the full gross premium as shown in _dollars_ and _cents_. For assistance, access **CalPERS On-Line**, at **www.calpers.ca.gov** , and search for the _Health Plan Rates_.
11 **_Primary Care Physician_**	Enter the name of a primary care physician and/or medical group. If you select an HMO but do not designate a Primary Care Physician/Medical Group, the plan will select one for you.
12 and **13** **_Prior Plan Code, Prior Health Plan_**	Enter this information only if you are changing plans or canceling coverage. For assistance, access **CalPERS On-Line** at **www.calpers.ca.gov** , and search for the _Health Plan Rates_.
14 **_Permitting Event Code (Reason Code)_**	Enter the appropriate transaction code, by locating the appropriate code in the Events/Reason Codes section of your manual. Complete a separate HBD-12 for each transaction that involves a different reason code or effective date.
15 **_Permitting Event Date_** (required)	Enter the date of an event that permits a change. Examples**:** The employee's appointment date, the date of marriage or divorce, the date of death, or the birth date of a dependent.
16 **_Effective Date_** **_Permissive_** and **_Mandatory Transactions_**	**Permissive transactions** are effective on the first of the month following the date the agency receives an enrollment form (Box 33), within 60 days of event. **Mandatory transactions** are effective on the first of the month following an event (Box 15). For Open Enrollment transactions, refer to the Open Enrollment section of your manual. For additional information on effective dates, refer to the Events, Effective Dates, and Reason Codes sections of your manual.

Members and Employers (continued)

Box	Process
<u>17</u> and/or **18** *Enrolled Family Members*	Use the appropriate **Action Code** to indicate *additions* or *deletions* of family members.

Action Code	Procedure
A	Use **A** to indicate the addition of family member(s), such as a new enrollment; mark the *Action Code* to the left of each enrollee's name
D	Use **D** to indicate the deletion of family member(s)

<u>Note</u>**:** Do not use *Action Codes* to change plans or to cancel coverage (use boxes **1** and **19** to change plans or cancel coverage). When adding or deleting dependents, place an *Action Code* next to their name(s), then list additional family members names (but **do not add** an *Action Code).*

List all family members as follows (avoid nicknames):
- First name (full)
- Middle (abbreviation)
- Last name (full)

List birthdate(s) as: MM/DD/YYYY

If possible, list Social Security Numbers for dependents other than a spouse (required) in Box 35 (Remarks).

Abbreviations for *family relationship codes*:

Family Relationship	Abbreviation
Wife	Wife
Husband	Husb
Son	Son
Daughter	Dtr
Stepson	S/Son
Stepdaughter	S/Dtr
Adopted Son	A/Son
Adopted Daughter	A/Dtr
All Others	Specify

<u>Note</u>**:** A Family Code is not required.

Members and Employers (continued)

Box	Process
<u>19</u> *Check One*	<table><tr><td>**I do not wish to enroll**</td><td>Check this box *only* when you wish to decline Health Benefits coverage. Request a copy from your HBO or Personnel Office.</td></tr><tr><td>**I elect to enroll**</td><td>Check this box for new enrollments and enrollment changes.</td></tr><tr><td>**I elect to cancel**</td><td>Check this box only for cancellation of all coverage, including "self." Do not check this box when deleting a family member.</td></tr></table>
<u>20</u> *Employee or Annuitant Signature*	You **must sign** the **HBD-12**. By doing so you: • Authorize premium deductions • Verify a health plan selection • Verify the eligibility of all enrolled family members • Please include a daytime phone number
<u>21</u> *Date Signed*	Enter the month, day, and year. <u>Remember</u>: *Permissive enrollment transactions are valid only when they are received in the employer's office and dated within 60 calendar days from the event date.* ***This is the last BOX a member/employee completes; the rest of the form must be processed by an HBO.***
<u>22-27</u> (Active State Employees only…all others, skip to Box 28)	<u>Note</u>: The State Controller's Office requires this information to start, change, or stop premium payments. Do not complete Boxes 22-27 if the transaction does not affect the premium payment, such as when adding a fourth family member.
<u>22</u> *Deduction Code*	Refer to Box 8 for instructions. Enter the 3-digit plan code, excluding the party code (last digit). <u>Examples</u>: Kaiser code **563** Coverage, enter: **056** (3 digit codes are preceded by 0). CCPOA Code **2742** Coverage, enter: **274**.
<u>23</u> *Type of Action*	Check the appropriate box (same as Box 1) <u>Note</u>**:** The cancel and change boxes are listed in reverse order for key‑entry reasons.

24 *Pay Period*	A pay period is the month prior to an effective date. In the three boxes, enter two digits for the pay period month and a last digit for the appropriate year. Examples: | Effective Date	Pay Period (Digits)
11/01/05	10 5
3/01/06	02 6	
25 *Party Code*	Enter the last digit of the plan code (1, 2, or 3).
26 *Employee Designation*	Enter the appropriate alpha code: | Alpha Code	Designation
R	Rank and file employees
S	Supervisory employees
M	Management
C	Confidential employees
E	Excluded	
27 *Bargaining Unit*	Enter the appropriate two-digit collective bargaining unit code.
28 *Agency Name*	Enter the agency's name (do not abbreviate).
29 *Payroll Office Code*	Enter the appropriate code, referring to the Payroll Office Code section for a complete listing.
30 and **31** *Agency* and *Unit Code*	Enter an employer's three-digit agency and unit code (where applicable).
32 *Signature of Health Benefits Officer* (required)	Signature of authorized Health Benefits Officer or assistant (signature must be legible).
33 *Date Received in Employing Office*	The employing office where an employee receives his or her lowest level of supervision (local timekeeper or attendance clerk).
34 *Phone Number*	Enter the public phone number of the Health Benefits Officer or assistant who is the contact for an enrollment document.

<u>35</u> *Remarks*	Use this section to enter additional information pertinent to the enrollment action and in numbering multiple documents. When there are multiple documents, please number them 1/4, 2/4, etc. You can also use this Box to: • List completed hours for a PI employee • Certify an HBD-35 is on file for an economic dependent addition • Explain coordination of coverage between family members • Verify a family member's eligibility • Explain any special circumstances